Senate

General Assembly

File No. 301

January Session, 2011

Substitute Senate Bill No. 16

Senate, March 31, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING STANDARDS FOR HEALTH CARE PROVIDER CONTRACTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subparagraph (B) of subdivision (15) of section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(B) Each insurer, or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than **[**forty-five**]** (i) sixty days after receipt by the insurer of the claimant's proof of loss form in paper format or the health care provider's request for payment in paper format filed in accordance with the insurer's practices or procedures, or (ii) fifteen days after the claimant or health care provider has electronically filed a claim or request for payment, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall **[**(i)**]** (I) send written notice to the claimant or health care provider, as the

case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and **[**(ii)**]** (II) pay claims for payment or reimbursement under the contract, for a claim or request that was filed in paper format, not later than thirty days after the insurer receives the information requested, and for a claim or request that was filed electronically, not later than fifteen days after the insurer receives the information requested.

Sec. 2. (NEW) (*Effective January 1, 2012*) The Insurance Commissioner shall establish procedures to be used by insurers, health care centers, fraternal benefit societies, hospital service corporations, medical service corporations or other entities delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy or medical benefits plan in this state providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes for the (1) solicitation of health care providers, as defined in section 38a-478 of the general statutes, to participate in provider networks of such entities, and (2) maintenance of provider participation in such networks.

Sec. 3. (NEW) (*Effective January 1, 2012*) Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, or preferred provider network, as defined in section 38a-479aa of the general statutes, that contracts with a health care provider, as defined in section 38a-478 of the general statutes, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the standards established by the National Committee for Quality Assurance's Managed Behavioral Healthcare Organization Standards and Guidelines for quality management and improvement.

Sec. 4. Subdivision (1) of subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu

thereof (*Effective January 1, 2012*):

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) If a utilization review company makes a prospective or concurrent determination to authorize or certify an admission, service, procedure or extension of stay, regardless of whether such authorization or certification is required or is requested by an enrollee's provider, no such utilization review company or insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity responsible for paying claims shall refuse to pay for such admission, service, procedure or extension of stay if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

[(E)**]** (F) Except as provided in subparagraph **[**(F)**]** (G) of this subdivision with respect to a final notice, each notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, and (iii) the procedure to appeal to the commissioner pursuant to section 38a-478n.

[(F)**]** (G) Each notice of a final determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) a statement that all internal appeal mechanisms have been exhausted, and (iii) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n.

Sec. 5. (NEW) (*Effective January 1, 2012*) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that preauthorizes or precertifies an admission,

service, procedure or extension of stay through other than a utilization review company, as defined in section 38a-226 of the general statutes, shall reverse such preauthorization or precertification or refuse to pay for such admission, service, procedure or extension of stay, if such admission, service, procedure or extension of stay has taken place in reliance on such preauthorization or precertification. The provisions of this section shall apply regardless of whether such preauthorization or precertification is required or is requested by an enrollee's health care provider.

Sec. 6. (NEW) (*Effective January 1, 2012*) (a) No contract between an insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an individual or group dental plan in this state and a dentist licensed pursuant to chapter 379 of the general statutes shall contain any provision that requires such dentist to provide services or procedures at a set fee to such entity's insureds or enrollees, unless such services or procedures are covered benefits under such insured's or enrollee's dental plan.

(b) The provisions of this section shall not apply to (1) a self-insured plan that covers dental services, or (2) a contract that is incorporated in or derived from a collective bargaining agreement or in which some or all of the material terms are subject to a collective bargaining process.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2012*	38a-816(15)(B)
Sec. 2	*January 1, 2012*	New section
Sec. 3	*January 1, 2012*	New section
Sec. 4	*January 1, 2012*	38a-226c(a)(1)
Sec. 5	*January 1, 2012*	New section
Sec. 6	*January 1, 2012*	New section

INS *Joint Favorable Subst.*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
Insurance Department	IF - Cost	Potential	Potential

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

This bill requires the Department of Insurance (DOI) to develop procedures by which an insurer develops and maintains provider networks. This provision is not anticipated to result in a fiscal impact.

However, should the establishment of such procedures be interpreted to require DOI to oversee and regulate the implementation of such procedures, a cost may result as this function is outside the current responsibilities of the department. The scope of this potential oversight is not known. For purposes of example, should DOI have to hire one additional principal examiner, the cost and fringe benefits would be approximately $125,000 annually.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sSB 16

AN ACT CONCERNING STANDARDS FOR HEALTH CARE PROVIDER CONTRACTS.

SUMMARY:

This bill makes a variety of changes in the laws relating to contracts between health care providers and health insurers. The bill:

1. increases the time an insurer has to pay paper claims and decreases the time it has to pay electronic claims;

2. requires the insurance commissioner to develop procedures by which an insurer develops and maintains a provider network;

3. requires an insurer to adhere to nationally accepted provider network standards;

4. requires an insurer to pay for certain health care services for which a prior authorization was received; and

5. generally prohibits provider contracts from setting a dentist's charges for services that are not covered benefits.

EFFECTIVE DATE: January 1, 2012

§ 1 — CLAIM PAYMENT REQUIREMENTS

Current law requires health insurers to pay claims within 45 days of receiving them. This bill instead requires them to pay claims submitted (1) on paper within 60 days and (2) electronically within 15 days. By law, if the claim does not include all required information, the insurer must send written notice to the claimant requesting the information be sent within 30 days. Under current law, upon receiving the requested information, the insurer must pay the claim within 30 days. The bill

retains the 30 day payment period for paper claims and reduces the payment period to 15 days for electronic claims.

By law, if an insurer fails to pay a claim on time, it must pay the claimant the amount of the claim plus 15% interest. This is in addition to any other penalties imposed by law. If the interest due is less than $1, the insurer must instead deposit the amount in a separate interest-bearing account. At the end of each calendar year, the insurer must donate the account funds to the UConn Health Center.

§ 2 — PROVIDER NETWORK PROCEDURES

The bill requires the insurance commissioner to establish procedures for insurers to use to (1) solicit licensed health care providers to participate in the insurers' provider networks and (2) maintain provider participation in the networks.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefit plans in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

§ 3 — PROVIDER NETWORK ADEQUACY

The bill requires each insurer that contracts with licensed health care providers to maintain a provider network that conforms to the standards established by the National Committee for Quality Assurance's (NCQA's) Managed Behavioral Healthcare Organization Standards and Guidelines for quality management and improvement.

For purposes of this section, insurers include HMOs, managed care organizations, preferred provider networks, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefits plans.

NCQA is a nonprofit organization that accredits and certifies a wide

range of health care organizations.

§ 4 — PRIOR AUTHORIZATIONS BY UTILIZATION REVIEW COMPANIES

By law, if utilization review companies grant prior or concurrent authorizations for admissions, services, procedures, or extensions of hospital stays, the companies cannot later reverse the authorizations. The bill prohibits the companies or insurers from refusing to pay for admissions, services, procedures, or extensions of stays that were provided in reliance on the prior authorizations.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital or medical service corporations, or other entities responsible for paying claims.

§ 5 — PRIOR AUTHORIZATIONS BY INSURER

Under the bill, if insurers grant prior authorizations for admissions, services, procedures, or extensions of hospital stays, other than through utilization review companies, and they take place in reliance on the prior authorizations, then the insurers cannot later reverse the authorizations or refuse to pay for the admissions, services, procedures, or extensions of stays.

For purposes of this section, insurers include HMOs, fraternal benefit societies, hospital and medical service corporations, and other entities that deliver, issue, renew, amend, or continue individual or group health insurance policies or medical benefit plans in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services.

§ 6 — DENTIST CHARGES

Under the bill, a provider contract between an insurer and a licensed dentist cannot require the dentist to provide services or procedures at a set fee unless the services or procedures are covered benefits under the dental plan. This does not apply to a self-insured plan or collectively bargained agreement.

For purposes of this section, an insurer includes an HMO, fraternal benefit society, hospital or medical service corporation, or other entity that delivers, issues, renews, amends, or continues an individual or group dental plan in Connecticut.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 9 (03/15/2011)